conflict with the previous treating team. When we explored this with him we discovered that he valued being a good father above everything else. To him this meant being able to pick up the children from school. If he took his tablets then he was too sleepy to meet the children reliably. Understanding his values led to a change in medication. He experienced voices more intrusively but he preferred to cope with his hallucinations if it enabled him to act as a good father.

Conclusions

Worldview is a useful concept to discuss the area where values, meaning and purpose, religion, spirituality and existential issues overlap. All individuals have a worldview, but so too do institutions. A values-based approach helps professionals to work with the worldviews and values of service users and to reach a consensus on the appropriate way forward.

References

Bikopo, D. B. (2010) Reflection on euthanasia: Western and African Ntomba perspectives on the death of a chief. *Developing World Bioethics*, **10**, 42–48.

Fulford, K. (2011) Bringing together values-based and evidence-based medicine: UK Department of Health initiatives in the 'personalization' of care. *Journal of Evaluation in Clinical Practice*, **17**, 341–343.

Gale, E. (2011) Exploring perspectives on cochlear implants and language acquisition within the deaf community. *Journal of Deaf Studies and Deaf Education*, **16**, 121–139.

Gray, A. (2010) Whatever happened to the soul? Some theological reflections on neuroscience. *Mental Health, Religion and Culture*, **6**, 637–648.

Hong, Y., Morris, M. W., Chiu, C., *et al* (2000) Multicultural minds. *American Psychologist*, **55**, 709–720.

Hughes, R. (2004) The death of children by faith-based medical neglect. *Journal of Law and Religion*, **20**, 247–265.

Joralemon, D. (2009) *Exploring Medical Anthropology.* Prentice Hall.

Josephson, A. M. & Peteet, J. R. (eds) (2004) *Handbook of Spirituality and Worldview in Clinical Practice*. American Psychiatric Publishing.

Koenig, H. G. (2008) *Medicine, Religion and Health: Where Science and Spirituality Meet.* Templeton Press.

La Cour, P. (2010) Research on meaning-making and health in secular society: secular, spiritual and religious existential orientations. *Social Science and Medicine*, **71**, 1292–1299.

Sire, J. W. (2004) *Naming the Elephant: Worldview as a Concept*. Intervarsity Press.

Spriggs, M. (2002) Lesbian couple create a child who is deaf like them. *Journal of Medical Ethics*, **28**, 283.

Swinton, J. & Pattison, S. (2010) Moving beyond clarity: towards a thin, vague, and useful understanding of spirituality in nursing care. *Nursing Philosophy*, **11**, 226–237.

Woodbridge, K. & Fulford, K. W. M. (2004) *Whose Values? A Workbook for Values-Based Practice in Mental Health Care*. Sainsbury Centre for Mental Health.

THEMATIC PAPER – FAITH AND PSYCHIATRY

The need for a category of 'religious and spiritual problems' in ICD-11

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The World Health Organization's International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders is currently working on the development of ICD-11 (World Health Organization, 2007). A more responsive ICD coding system should incorporate recent work which suggests that the religious and spiritual domain is important for a comprehensive, culturally sensitive diagnosis and management plan (e.g. Sims, 1992, 2004; Koenig *et al*, 2008). A 'religious or spiritual problems' category, similar to that in DSM-IV (American Psychiatric Association, 1994), should be included in ICD-11.

I was alerted to the importance of this domain when undertaking a project in 1988 to assess the mental health problems and psychiatric needs of homeless people in London, using the observer-rated Social Behaviour Schedule (SBS) to detect behavioural problems associated with chronic psychiatric disorder. For one hostel resident, the SBS recorded posturing, mannerisms, and talking and laughing to oneself. There had been no indication of any such problems during a psychiatric interview conducted earlier. What were perceived as 'behavioural problems' by the staff were the resident's daily Muslim prayers carried out in the hostel corridor, as there was no space for prayer in his cubicle.

This experience gave the author an insight into the importance of understanding the nature of religious practices when undertaking psychiatric assessments. Personal spiritual practices, such as prayer or reading from holy books, as well as communal events such as worship and shared prayers, are found in most of the world faiths. 'Spirituality' (the quality of being spiritual) is a term used to refer to these practices, corporate rituals and beliefs that give meaning and purpose to life, which may be independent of the institutional structures and prescribed beliefs of a particular world religion.

Psychiatry and religion

Although psychiatry and psychology are linguistically associated with spirit (psyche), their boundary with religion has been fraught with many complications and misunderstandings (Albuquerque *et al*, 2003). Marks (2006) suggested that the subject of religion in psychiatry and medicine is

often avoided because of its association with the terrifying existential question 'Is this life all there is?' Sims (2004), commenting on the finding that some forms of mainstream religious practice were good for health, asked whether this was epidemiological medicine's 'best-kept secret'. Those who were religious were found by Dein (2006) to have a lower incidence of depression and recovered more quickly.

Much of the research in this area has been carried out in Western, high-income countries. Most of the studies reviewed by Koenig *et al* (2008), for instance, were carried out in Europe and North America. Two recent exceptions may be cited. Abdel-Khalek (2006) surveyed 2210 Kuwaiti undergraduate students using a self-rating scale that covered religiosity, happiness and mental health and found that those who were religious reported greater happiness. Vasegh & Mohammadi (2007) in their cross-sectional study of 285 medical students at Tehran University found that those reporting higher scores on scales assessing religious feeling were less likely to score highly on depression and anxiety, although this association was statistically significant only for anxiety. There is still, though, a pressing need to conduct research in other regions of the world and to review the existing world literature on this subject.

Religion and psychopathology

The American Psychiatric Association's 1994 classification (DSM-IV) included the category V62.89, 'Religious or spiritual problems', in response to the perceived need to assist clinicians working in multifaith communities and to encourage training in this field. This category of problem was not included in the World Health Organization's 1992 ICD-10, although clinical experience in other regions of the world, as well as the published literature, suggest that religious and spiritual problems are universal, with a consequent need to distinguish, for example, a possession state from a psychotic illness. In many non-Western cultures the patient may ascribe mental disorder to religious beliefs or to spiritual or religious causes. In many traditional cultures there is a strong belief in the power of evil to inflict misfortune and illness, particularly mental illness. In the UK and the USA, about a third of the population report having at some stage of their lives mystical religious experiences of a type that could easily be misidentified by health professionals as mental disorders (Dein, 2004).

Psychiatric classification and religion

Any comprehensive diagnostic system should include criteria that ensure that the social, cultural and spiritual contexts are fully considered. This diagnostic approach requires a combination of descriptive and narrative considerations, as well as the need for recovery strategies and for an understanding of the nature of positive health (Cox, 1994).

The present dominant biochemical–behaviourist model emphasises neither these transcultural perspectives nor the humanistic, relationship-based therapies – an apparent neglect that has resulted in the dehumanising of psychiatry and its promotion solely as a technical craft (Albuquerque *et al*, 2003; Browning, 2003; Meares, 2003).

The American Psychiatric Association's Committee on Religion, Spirituality, and Psychiatry has been helpfully proactive in this regard by ensuring greater sensitivity in DSM-IV to religious factors, and this work is continuing with DSM-V. The Association's book *Religious and Spiritual Issues in Psychiatric Diagnosis* (Peteet *et al*, 2011) is likely to have international relevance and its content will be pertinent to the development of ICD-11. In summary the DSM-IV category V62.89, 'Religious or spiritual problems', is found to be very useful in clinical practice, as is the associated advice about the cultural formulation, which states that this category is used:

> when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution. (American Psychiatric Association, 1994)

ICD-10 did not include a similar category to cover these aspects of the religious or spiritual dimension of mental health, which could have provided assistance with complex differential diagnoses. Applying diagnostic criteria without consideration of religious factors could lead to an inappropriate diagnosis and to an inadequate management plan. ICD-11 should therefore encourage greater consideration of religious belief and spiritual practice by incorporating more specific advice in this area of human experience.

References

Abdel-Khalek, A. M. (2006) Happiness, health, and religiosity: significant relations. *Mental Health, Religion and Culture*, **9**, 85–97.

Albuquerque, J., Deshauer, D. & Grof, P. (2003) Descartes' passions of the soul: seeds of psychiatry? *Journal of Affective Disorders*, **76**, 285–291.

American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders* (4th edition) (DSM-IV). APA.

Browning, D. (2003) Internists of the mind or physicians of the soul: does psychiatry need a public philosophy? *Australian and New Zealand Journal of Psychiatry*, **37**, 131–137.

Cox, J. L. (1994) Psychiatry and religion: a general psychiatrist's perspective. *Psychiatric Bulletin*, **18**, 673–676.

Dein, S. (2004) Working with patients with religious beliefs. *Advances in Psychiatric Treatment*, **10**, 287–294.

Dein, S. (2006) Religion, spirituality and depression: implications for research and treatment. *Primary Care and Community Psychiatry*, **11**, 67–72.

Koenig, H. G., McCullough, M. E. & Larson, D. B. (2008) *Handbook of Religion and Health*. Oxford University Press.

Marks, L. D. (2006) Mental health, religious belief, and the terrifying question. *Journal of Child and Family Studies*, **15**, 135–141.

Meares, R. (2003) Towards a psyche for psychiatry. *Australian and New Zealand Journal of Psychiatry*, **37**, 689–695.

Peteet, J. R., Lu, F. G. & Narrow, W. E. (2011) *Religious and Spiritual Issues in Psychiatric Diagnosis: A Research Agenda for DSM-V*. American Psychiatric Publishing.

Sims, A. C. P. (1992) Symptoms and beliefs. *Journal of the Royal Society of Health*, **112**, 42–46.

Sims, A. (2004) Epidemiological medicine's best-kept secret? Invited commentary on… Working with patients with religious beliefs. *Advances in Psychiatric Treatment*, **10**, 294–295.

Vasegh, S. & Mohammadi, M. R. (2007) Religiosity, anxiety, and depression among a sample of Iranian medical students. *International Journal of Psychiatry in Medicine*, **37**, 213–227.

World Health Organization (1992) *The ICD Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines* (10th revision) (ICD-10). WHO.

World Health Organization (2007) Meeting of the International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders. 11–12 January 2007, Geneva. http://www.who.int/mental_health/evidence/icd_advisory_group_meeting_jan_%202007_summary.pdf (accessed June 2010).